Crime Victim Services Division
Crime Victims' Compensation Program

Mental Health Form

Date: _____

1. Claim Number: _____

Date of Crime: _____

PATIENT INFORMATION

2. Name: FN MI LN	**3. Date of Birth:**	**4. Social Security Number:**
5. Parent/ Legal Guardian:	**6. Date of First Treatment:**	

7. DSM-V DIAGNOSES (Indicate both the diagnosis and corresponding code.)

TREATMENT ISSUES

8. Presenting Problem and its Relationship to the Crime

Describe, in detail, the problems for which the patient is seeking treatment including observable cognitive, behavioral and emotional symptoms displayed by the victim. ***Note: You must inform CVC Program if this is court ordered evaluation or treatment.***

9. History

Does the patient have a history of previous mental health treatment? **If so, indicate the dates of treatment, reason(s) for the treatment, the types of treatment and the name of the provider in the box below.**	**Yes**	**No**
Are there any pre-existing mental health issues affected (exacerbated) or disclosed by the crime? If so, describe below.	**Yes**	**No**
Was there prior victimization or psychological trauma? **If so, describe below.**	**Yes**	**No**

10. Describe the patient's current level of functioning, noting areas of impairment

Social:

Psychological:

Family:

Vocational:

Economic:

11. TREATMENT PLAN

Describe the short-term treatment goals (less than three months).

Describe the long-term treatment goals (longer than three months).

What is the prognosis?

Anticipated Termination Date (must enter date): _____

12. DISABILITY

Is the patient unable to work due to the mental health condition related to the crime? If so, describe the nature and anticipated length of the disability below. **Yes** **No**

13. INSURANCE

Does the patient have a health care plan? **Yes** **No**

Is the patient currently on Medicaid or any other public insurance plan? (CVC does not need this form if Medicaid is payer). **Yes** **No**
Medicaid Provider Number_____

If "Yes" to either of the above, have you filed a claim with the insurer? On what date? _____ **Yes** **No**
(Ins explanation of benefits must accompany bill.)

Date _____

If the patient has a health care plan, complete the following:

Name of Carrier:	**Carrier Address:**
Policy Number:	**Group Number:**

14. Is the patient/client receiving counseling under a grant, free counseling, or reduced fee reimbursement (such as a sliding scale). If so, explain:

_____

_____

15. PROVIDER INFORMATION

Name:	**Name of Agency:**	
Address, City, State, Zip Code:	**Telephone Number: ( )** **Fax Number: ( )**	
License Number: **Expiration Date:**	**Discipline/Title:**	**(If licensed Intern) List Supervisor / License Number:** **Board-Approved Supervisor / License Number:**

Signature: _____ Date: _____